Third Party Liability

(1) California obtains information for the purpose of determining the legal liability of third parties from data exchanges with the State Wage and Income Collection Agencies (SWICA), SSA wage and earnings data, State Title IV-A Agency, and State Workers Compensation files and from the diagnosis and trauma code edits on a monthly basis.

California has a waiver for conducting a data exchange with the State Department of Motor Vehicles (DMV), since accident reports do not provide enough information to enable identification of a Medicaid beneficiary.

(2) The methods the California Medicaid agency uses for meeting the follow-up requirements contained in 42 CFR 433.138 (g)(1)(i) and (g)(2)(i) are as follows:

SWICA, SSA Wage and Earnings File, and State Title IV-A Agency

The California Medicaid agency's Income and Eligibility Verification System (IEVS) crossmatches applicant and recipient identification data with earning and income files consisting of State wage data; unemployment insurance benefit and income data; social security wage, benefits and income data; and the Internal Revenue Service and/or Franchise Tax Board unearned income data. The IEVS match is performed for all persons applying for, or receiving, Aid to Families with Dependent Children (Title IV-A) and Medi-Cal Only. The Department utilizes the IEVS earnings and income data match to identify potential Other Health Coverage in Medi-Cal cases. The county eligibility worker issues a Health Insurance Questionnaire (form DHS 6155) to an applicant with a current or past work history identified by IEVS, if health coverage is/was an employment benefit. These forms identify whether the county worker obtained the employment information from an IEVS match. The county eligibility worker enters the appropriate OHC code on the Medi-Cal Eligibility Data System (MEDS).

The completed DHS 6155 is then sent to the Department. The Department applies priority processing to the IEVS-identified DHS 6155 forms. Priority processing initiates update to the Health Insurance System (HIS) file within the federally-required forty-five (45) day time period.

Collection of Health Insurance Information During Initial Application and Redetermination Processes for Medicaid Eligibility

Under California's Medicaid Program, eligibility determinations are performed by fifty-eight county welfare departments for individuals applying for Aid to Families with Dependent Children and the Medically Needy Program, and by the Social Security administration (SSA), in accordance with a 1634 agreement for individuals who apply for Supplemental Security Income/State Supplemental Program (SSI/SSP) benefits. Health insurance information is collected by county eligibility and SSA staff and reported to the Department for inclusion in the Medicaid Management Information System (MMIS) data base.

The collection of health insurance information is performed during the initial application and redetermination process. County eligibility and SSA staff ask the applicant whether health insurance is available. Where an indication of insurance exists, the applicant, or the parent or guardian of the applicant is given a health insurance form to complete. The county welfare departments use the Health Insurance Questionnaire (DHS 6155) form and SSA uses the TPL Information Statement (SSA-8019-U2) form to collect and report applicant health insurance information to the Department. The county eligibility workers are also responsible for noting coverage in the eligibility case file and coding the recipients' case records on the automated Medi-Cal Eligibility Data System (MEDS) with Health Insurance indicator codes. Since SSA does not have access to MEDS, the Health Insurance coding of SSI/SSP recipients' case records is performed by the Department. The Health Insurance codes are printed on the Medi-Cal identification cards to alert providers to bill the insurance coverage. Codes are also passed to the State's fiscal intermediary via the Fiscal Intermediary Access to MEDS Eligibility (FAME) file for processing claims involving private health insurance. As federally required, the Department updates the HIS file within sixty (60) of receiving the health insurance information.

Collection of Health Insurance Information by the Child Support Enforcement Program

The Child and Medical Support (IV-D) Program is administered by the Department of Social Services through the County District Attorney Offices, Family Support Divisions. These are known as the California Child Support Enforcement agencies or local IV-D agencies. These IV-D agencies play an important role in medical support establishment and enforcement. They are responsible for securing and enforcing court orders requiring the Absent Parent (AP) to obtain and maintain health insurance coverage for dependent children who do not reside in the AP's home. The IV-D agencies are also required to transmit relevant AP health insurance information to the Department when medical support is secured for the Medi-Cal eligible dependent child through a court or administrative order.

The IV-D agencies report AP health insurance information to the Department via the Medical Insurance Form (DHS 6110). This form is designed to be completed by the Medi-Cal dependent's parents, employer of the AP, other third party providing health insurance to the AP, or the IV-D agency. The completed forms are sent by the IV-D agencies to the Department for review and processing. Since Federal regulations exclude IV-D cases from cost avoidance, the Department updates MEDS with the appropriate post payment recovery code and adds billing information to the Health Insurance System (HIS) file. The only exception to coding with a post payment recovery code is if the Medi-Cal dependent's insurance coverage is through a prepaid health care delivery system; then the case is coded for cost avoidance. The Department updates the HIS file within sixty (60) days of receiving the DHS 6110 form as is federally required.

Other Health Insurance Collection Sources

The Department also obtains beneficiary health insurance information from other sources. These sources are as follows:

Referrals:

Referrals are acknowledgments received either through correspondence or telephone calls from beneficiaries, medical providers, and other government or private agencies informing the Department that a Medi-Cal beneficiary has other health coverage. Each referral is developed by Department staff in order to obtain all necessary beneficiary health insurance information. Referrals that require additional information are researched through the source of the referral or by sending a Health Insurance Questionnaire (DHS 6155A) to the beneficiary. Once complete health insurance information is obtained, it is input into the Health Insurance System (HIS) file to be utilized for program post payment billings and cost avoidance. The Department also updates MEDS with the appropriate Other Health Coverage (OHC) indicator code.

Medi-Cal Claims Processing System:

Within the Medi-Cal claims processing system, the Medi-Cal Fiscal Intermediary (FI) identifies claims with potential third party liability. The providers are instructed to enter any insurance payments in a field on the claim called "Amount Other Coverage Paid". If an amount is entered in this field, the FI looks at the Other Health Coverage (OHC) code on the FAME file. The FI creates a monthly file of Social Security Numbers of beneficiaries whose claims have an amount in this field, but no OHC code on the FAME file. The Department then mails Health Insurance Questionnaires (DHS 6155As) to these beneficiaries to obtain specific health insurance information. Upon receipt of the completed DHS 6155A, the Department enters the new health insurance information on the Health Insurance System (HIS) file and updates MEDS with the appropriate OHC indicator code. This in turn creates a transaction to the FI which provides sufficient information to bill the insurance carrier for any claims paid on behalf of these beneficiaries where the provider had not indicated an insurance payment. The HIS information is also input to the FAME file and coded on the Medi-Cal card so that future claims will be cost avoided.

Health Insurance Premium Payment TPL Review:

When an individual inquires about participation in the Health Insurance Premium Payment (HIPP) Program, Department staff requests the individual's Social Security Number in order to review MEDS for share of cost, Other Health Coverage (OHC) information, Medicare entitlement and Medi-Cal eligibility. If MEDS indicates no OHC code, the individual is asked if he/she has health insurance coverage. If the individual responds in the affirmative, he/she is asked to provide specific health insurance information (i.e., carrier name, carrier address, policy number, and scope of coverage). Once complete information is obtained, the Department updates MEDS with the appropriate OHC indicator code and the Health Insurance System (HIS) file.

Workers' Compensation

California's Medicaid agency receives copies of all Workers' Compensation Appeals claims. Within sixty (60) days, these claims are matched against eligibility files to identify Medi-Cal eligibles. If Medi-Cal eligibility is identified, a potential third party liability case is established and an investigation is made to determine if a recovery can be made. In addition, copies of applications for adjudication are sent to the Department of Social Services (DSS). In turn, DSS sends these copies to the appropriate local IV-D agency District Attorney (DA) office. If the absent parent has employer related health insurance coverage available, the county DA office provides follow-up service to identify whether the appeal can be linked to an active Medi-Cal dependent IV-D case. If the DA discovers employer coverage, the DA requires the absent parent, through a court or administrative order, to provide health insurance and to complete a medical insurance form (DHS 6110). The completed DHS 6110 forms are sent by the DA's office to the Department.

(3) As stated in Section "Third Party Liability (1)", California's Medicaid agency does not obtain information from DMV.

(4) The Medicaid agency conducts edits of paid claims to identify treatment provided as a result of injury using diagnosis codes 800 through 999, with the exception of 994.6. The Department generates letters, seeking potential third party liability information, to recipients who have received $500 or more in paid services when the service listed on the claim relates to an injury diagnosis. If there is no response within sixty (60) days and paid claims exceed $750, a second letter is sent. If no response is received, a follow-up file is printed and personal contact is attempted by staff.

A quarterly report is generated indicating the number and total dollar value of all cases by individual trauma code. A second report, generated semi-annually, lists recoveries made by trauma code.

(5) In addition to the federally required data exchanges, the California Medicaid agency also conducts the following optional data exchanges:

Private Health Insurance Carrier Data Exchanges

To identify Medi-Cal eligibles with private health coverage, the California Medicaid agency conducts data matches with a variety of private health insurance carriers and other third party entities. Carriers are identified for data matches based on carrier size and cost benefit of the match. Data matches are also conducted by the Department's private contingency fee contractor(s). The Department or its contractor negotiates contracts and produces exchange tapes. From the resulting information, the Department updates beneficiary health insurance information on MEDS and the Department's HIS file. Through data matches, Medi-Cal beneficiaries having health coverage with the health insurance carrier at present or any time during the past six months are identified.

BENDEX

The California Medicaid agency uses the BENDEX system to identify the Social Security status and changes to a Medi-Cal beneficiary's Social Security benefits or earnings. The Department also uses the BENDEX system to identify Medicare Part A and B entitlement, option codes, effective dates, termination dates, and termination codes. The automated Buy-In system interfaces with MEDS to extract Medicare entitlement information from the BENDEX file and initiates changes on MEDS. This information is then used in the Medicare coding of the Medi-Cal card.

The Department of Social Services uses the BENDEX file for verification of AFDC recipient unearned income. This information is provided to counties through the Payment Verification System (PVS), which is a subset of IEVS. In addition, verification of wages is provided to counties from information in the Beneficiary Earnings Exchange Record (BEER) through the PVS. The BEER is part of the BENDEX.